OMB No. 0930-0285
Expiration Date XX/XX/XXXX

Center for Mental Health Services

NOMs Client-Level Measures for Discretionary Programs Providing Direct Services

SERVICES TOOL
For Adult Programs

CMHS
Center for Mental Health Services
SAMHSA

RECORD MANAGEMENT

[RECORD MANAGEMENT IS REPORTED BY GRANTEE STAFF AT BASELINE, REASSESSMENT AND DISCHARGE REGARDLESS OF WHETHER AN INTERVIEW IS CONDUCTED.]

Consumer ID |____|____|____|____|____|____|____|____|____|____|____|

Grant ID (Grant/Contract/Cooperative Agreement) |____|____|____|____|____|____|____|____|____|____|____|

Site ID |____|____|____|____|____|____|____|____|____|____|

1. Indicate Assessment Type:

☐ Baseline ***[ENTER THE MONTH AND YEAR WHEN THE CONSUMER FIRST RECEIVED SERVICES UNDER THE GRANT FOR <u>THIS</u> EPISODE OF CARE.]*** |____|____| / |____|____|____|____ | MONTH YEAR	☐ Reassessment **Which 6-month reassessment?** |____|____| ***[ENTER 06 FOR A 6–MONTH, 12 FOR A 12–MONTH, 18 FOR AN 18–MONTH ASSESSMENT, ETC.]***	☐ Clinical Discharge

2. Was the interview conducted?

☐☐Yes **When?** ||| / ||| / ||| || MONTHDAY YEAR	☐☐No **Why not? Choose only one.** ☐Not able to obtain consent from proxy ☐Consumer was impaired or unable to provide consent ☐Consumer refused this interview only ☐Consumer was not reached for interview ☐Consumer refused all interviews

3. Behavioral Health Diagnoses

Please indicate the consumer's current behavioral health diagnoses using the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) codes listed below. Please note that some substance use disorder ICD-10-CM codes have been crosswalked to Diagnostic and Statistical Manual of Mental Disorders, (DSM-5) descriptors.

Select up to three diagnoses. For each diagnosis selected, please indicate whether it is primary, secondary, or tertiary, if known. Only one diagnosis can be primary, only one can be secondary, and only one can be tertiary.

	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary or tertiary if known.		
	Select up to three.	Primary	Secondary	Tertiary
SUBSTANCE USE DISORDER DIAGNOSES				
Alcohol Related Disorders				
F10.10 – Alcohol use disorder, uncomplicated, mild	☐	☐	☐	☐
F10.11 – Alcohol use disorder, mild, in remission	☐	☐	☐	☐
F10.20 – Alcohol use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F10.21 – Alcohol use disorder, moderate/severe, in remission	☐	☐	☐	☐
F10.9 – Alcohol use, unspecified	☐	☐	☐	☐
Opioid related disorders				
F11.10 – Opioid use disorder, uncomplicated, mild	☐	☐	☐	☐
F11.11 – Opioid use disorder, mild, in remission	☐	☐	☐	☐
F11.20 – Opioid use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F11.21 – Opioid use disorder, moderate/severe, in remission	☐	☐	☐	☐
F11.9 – Opioid use, unspecified	☐	☐	☐	☐
Cannabis related disorders				
F12.10 – Cannabis use disorder, uncomplicated, mild	☐	☐	☐	☐
F12.11 – Cannabis use disorder, mild, in remission	☐	☐	☐	☐
F12.20 – Cannabis use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F12.21 – Cannabis use disorder, moderate/severe, in remission	☐	☐	☐	☐
F12.9 – Cannabis use, unspecified	☐	☐	☐	☐
Sedative, hypnotic, or anxiolytic related disorders				
F13.10 – Sedative, hypnotic, or anxiolytic-related use disorder, uncomplicated, mild	☐	☐	☐	☐
F13.11 – Sedative, hypnotic, or anxiolytic-related use disorder, mild, in remission	☐	☐	☐	☐
F13.20 – Sedative, hypnotic, or anxiolytic-related use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F13.21 – Sedative, hypnotic, or anxiolytic-related use disorder, moderate/severe, in remission	☐	☐	☐	☐
F13.9 – Sedative, hypnotic, or anxiolytic-related use, unspecified	☐	☐	☐	☐
Cocaine related disorders				
F14.10 – Cocaine use disorder, uncomplicated, mild	☐	☐	☐	☐
F14.11 – Cocaine use disorder, mild, in remission	☐	☐	☐	☐

	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary or tertiary if known.		
	Select up to three.	**Primary**	**Secondary**	**Tertiary**
F14.20 – Cocaine use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F14.21 – Cocaine use disorder, moderate/severe, in remission	☐	☐	☐	☐
F14.9 – Cocaine use, unspecified	☐	☐	☐	☐
Other stimulant related disorders				
F15.10 – Other stimulant use disorder, uncomplicated, mild	☐	☐	☐	☐
F15.11 – Other stimulant use disorder, mild, in remission	☐	☐	☐	☐
F15.20 – Other stimulant use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F15.21 – Other stimulant use disorder, moderate/severe, in remission	☐	☐	☐	☐
F15.9 – Other stimulant use, unspecified	☐	☐	☐	☐
Hallucinogen related disorders				
F16.10 – Hallucinogen use disorder, uncomplicated, mild	☐	☐	☐	☐
F16.11 – Hallucinogen use disorder, mild, in remission	☐	☐	☐	☐
F16.20 – Hallucinogen use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F16.21 – Hallucinogen use disorder moderate/severe, in remission	☐	☐	☐	☐
F16.9 – Hallucinogen use, unspecified	☐	☐	☐	☐
Inhalant related disorders				
F18.10 – Inhalant use disorder, uncomplicated, mild	☐	☐	☐	☐
F18.11 – Inhalant use disorder, mild, in remission	☐	☐	☐	☐
F18.20 – Inhalant use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F18.21 – Inhalant use disorder, moderate/severe, in remission	☐	☐	☐	☐
F18.9 – Inhalant use, unspecified	☐	☐	☐	☐
Other psychoactive substance related disorders				
F19.10 – Other psychoactive substance use disorder, uncomplicated, mild	☐	☐	☐	☐
F19.11 – Other psychoactive substance use disorder, in remission	☐	☐	☐	☐
F19.20 – Other psychoactive substance use disorder, uncomplicated, moderate/severe	☐	☐	☐	☐
F19.21 – Other psychoactive substance use disorder, moderate/severe, in remission	☐	☐	☐	☐
F19.9 – Other psychoactive substance use, unspecified	☐	☐	☐	☐
Nicotine dependence				

	Diagnosed?	For each diagnosis selected, please indicate whether diagnosis is primary, secondary or tertiary if known.		
	Select up to three.	Primary	Secondary	Tertiary
F17.20 – Tobacco use disorder, mild/moderate/severe	☐	☐	☐	☐
F17.21 – Tobacco use disorder, mild/moderate/severe, in remission	☐	☐	☐	☐
MENTAL HEALTH DIAGNOSES				
F20 – Schizophrenia	☐	☐	☐	☐
F21 – Schizotypal disorder	☐	☐	☐	☐
F22 – Delusional disorder	☐	☐	☐	☐
F23 – Brief psychotic disorder	☐	☐	☐	☐
F24 – Shared psychotic disorder	☐	☐	☐	☐
F25 – Schizoaffective disorders	☐	☐	☐	☐
F28 – Other psychotic disorder not due to a substance or known physiological condition	☐	☐	☐	☐
F29 – Unspecified psychosis not due to a substance or known physiological condition	☐	☐	☐	☐
F30 – Manic episode	☐	☐	☐	☐
F31 – Bipolar disorder	☐	☐	☐	☐
F32 – Major depressive disorder, single episode	☐	☐	☐	☐
F33 – Major depressive disorder, recurrent	☐	☐	☐	☐
F34 – Persistent mood [affective] disorders	☐	☐	☐	☐
F39 – Unspecified mood [affective] disorder	☐	☐	☐	☐
F40-F48 – Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	☐	☐	☐	☐
F50 – Eating disorders	☐	☐	☐	☐
F51 – Sleep disorders not due to a substance or known physiological condition	☐	☐	☐	☐
F60.2 – Antisocial personality disorder	☐	☐	☐	☐
F60.3 – Borderline personality disorder	☐	☐	☐	☐
F60.0, F60.1, F60.4-F69 – Other personality disorders	☐	☐	☐	☐
F70-F79 – Intellectual disabilities	☐	☐	☐	☐
F80-F89 – Pervasive and specific developmental disorders	☐	☐	☐	☐
F90 – Attention-deficit hyperactivity disorders	☐	☐	☐	☐
F91 – Conduct disorders	☐	☐	☐	☐
F93 – Emotional disorders with onset specific to childhood	☐	☐	☐	☐
F94 – Disorders of social functioning with onset specific to childhood or adolescence	☐	☐	☐	☐
F95 – Tic disorder	☐	☐	☐	☐
F98 – Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence	☐	☐	☐	☐
F99 – Unspecified mental disorder	☐	☐	☐	☐

○ DON'T KNOW
○ NONE OF THE ABOVE

[IF THIS IS A BASELINE, GO TO SECTION A.]

[FOR ALL REASSESSMENTS:
IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION B.
IF AN INTERVIEW WAS NOT CONDUCTED, GO TO SECTION I.]

[FOR A CLINICAL DISCHARGE:
IF AN INTERVIEW WAS CONDUCTED, GO TO SECTION B.
IF AN INTERVIEW WAS NOT CONDUCTED, GO TO SECTION J.]

A. DEMOGRAPHIC DATA

[SECTION A IS ONLY COLLECTED AT BASELINE. IF THIS IS NOT A BASELINE, GO TO SECTION B.]

1. What is your gender?

- ☐ MALE
- ☐ FEMALE
- ☐ TRANSGENDER
- ☐ OTHER (SPECIFY) _____
- ☐ REFUSED

2. Are you Hispanic or Latino?

- ☐ YES
- ☐ NO *[GO TO 3.]*
- ☐ REFUSED *[GO TO 3.]*

***[IF YES]* What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.**

	YES	NO	REFUSED	
Central American	☐	☐	☐	
Cuban	☐	☐	☐	
Dominican	☐	☐	☐	
Mexican	☐	☐	☐	
Puerto Rican	☐	☐	☐	
South American	☐	☐	☐	
OTHER (SPECIFY) _____	☐	☐	☐	*[IF YES, SPECIFY BELOW.]*

3. What race do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.

	YES	NO	REFUSED
Alaska Native	☐	☐	☐
American Indian	☐	☐	☐
Asian	☐	☐	☐
Black or African American	☐	☐	☐
Native Hawaiian or other Pacific Islander	☐	☐	☐
White	☐	☐	☐

4. What is your month and year of birth?

|____|____| / |____|____|____|____|
MONTH YEAR ☐ REFUSED

A. DEMOGRAPHIC DATA (Continued)

5. Which one of the following do you consider yourself to be?

- ☐ Heterosexual, that is straight
- ☐ [IF FEMALE, THEN "Lesbian"] or Gay
- ☐ Bisexual
- ☐ OTHER (SPECIFY) _____
- ☐ REFUSED
- ☐ DON'T KNOW

[IF AN INTERVIEW WAS CONDUCTED CONTINUE TO SECTION B.]

[IF AN INTERVIEW WAS NOT CONDUCTED:
GO TO SECTION H (IF APPLICABLE).
GRANTEES IN ALL OTHER PROGRAMS STOP HERE.]

B. FUNCTIONING

1. How would you rate your overall health right now?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor
- ○ REFUSED
- ○ DON'T KNOW

2. **Please select the one answer that most closely matches your situation.** ***I feel capable of managing my health care needs:***

- ○ On my own most of the time
- ○ On my own some of the time and with support from others some of the time
- ○ With support from others most of the time
- ○ Rarely or never
- ○ REFUSED
- ○ DON'T KNOW

3. In order to provide the best possible mental health and related services, we need to know what you think about how well you were able to deal with your everyday life <u>during the past 30 days</u>. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**	**NOT APPLICABLE**
a. I deal effectively with daily problems.	□	□	□	□	□	□	
b. I am able to control my life.	□	□	□	□	□	□	
c. I am able to deal with crisis.	□	□	□	□	□	□	
d. I am getting along with my family.	□	□	□	□	□	□	□
e. I do well in social situations.	□	□	□	□	□	□	
f. I do well in school and/or work.	□	□	□	□	□	□	□
g. My housing situation is satisfactory.	□	□	□	□	□	□	

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**	**NOT APPLICABLE**
h. My symptoms are not bothering me.	☐	☐	☐	☐	☐	☐	

B. FUNCTIONING (Continued)

4. The following questions ask about how you have been feeling during the past 30 days. For each question, please indicate how often you had this feeling.

[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

QUESTION	RESPONSE OPTIONS						
During the past 30 days, about how often did you feel …	**All of the Time**	**Most of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**	**REFUSED**	**DON'T KNOW**
a. nervous?	☐	☐	☐	☐	☐	☐	☐
b. hopeless?	☐	☐	☐	☐	☐	☐	☐
c. restless or fidgety?	☐	☐	☐	☐	☐	☐	☐
d. so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐	☐	☐
e. that everything was an effort?	☐	☐	☐	☐	☐	☐	☐
f. worthless?	☐	☐	☐	☐	☐	☐	☐
QUESTION	RESPONSE OPTIONS						
During the past 30 days…	**Not at All**	**Slightly**	**Moderately**	**Considerably**	**Extremely**	**REFUSED**	**DON'T KNOW**
g. how much have you been bothered by these psychological or emotional problems?	☐	☐	☐	☐	☐	☐	☐

B. FUNCTIONING (Continued)

5. The following questions ask about how you have been feeling during the last 4 weeks.

[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

QUESTION	RESPONSE OPTIONS						
In the last 4 weeks …	**Very Poor**	**Poor**	**Neither Good nor Poor**	**Good**	**Very Good**	**REFUSED**	**DON'T KNOW**
a. how would you rate your quality of life?	☐	☐	☐	☐	☐	☐	☐
QUESTION	RESPONSE OPTIONS						
In the last 4 weeks …	**Not at All**	**A Little**	**Moderately**	**Mostly**	**Completely**	**REFUSED**	**DON'T KNOW**
b. do you have enough energy for everyday life?	☐	☐	☐	☐	☐	☐	☐
QUESTION	RESPONSE OPTIONS						
In the last 4 weeks …	**Very Dissatisfied**	**Dissatisfied**	**Neither Satisfied nor Dissatisfied**	**Satisfied**	**Very Satisfied**	**REFUSED**	**DON'T KNOW**
c. how satisfied are you with your ability to perform your daily living activities?	☐	☐	☐	☐	☐	☐	☐
d. how satisfied are you with your health?	☐	☐	☐	☐	☐	☐	☐
e. how satisfied are you with yourself?	☐	☐	☐	☐	☐	☐	☐
f. how satisfied are you with your personal relationships?	☐	☐	☐	☐	☐	☐	☐

B. FUNCTIONING (Continued)

6. The following questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed.

[READ EACH QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

QUESTION	RESPONSE OPTIONS					
In the past 30 days, how often have you used…	**Never**	**Once or Twice**	**Weekly**	**Daily or Almost Daily**	**REFUSED**	**DON'T KNOW**
a. tobacco products (cigarettes, chewing tobacco, cigars, etc.)?	☐	☐	☐	☐	☐	☐
b. alcoholic beverages (beer, wine, liquor, etc.)?	☐	☐	☐	☐	☐	☐
b1. *[IF B >= ONCE OR TWICE, AND RESPONDENT MALE]*, How many times in the past 30 days have you had five or more drinks in a day? *[CLARIFY IF NEEDED:* A standard drink (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor)*].*	☐	☐	☐	☐	☐	☐
b2. *[IF B >= ONCE OR TWICE, AND RESPONDENT NOT MALE]*, How many times in the past 30 days have you had four or more drinks in a day? *[CLARIFY IF NEEDED:* A standard drink (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor)*].*	☐	☐	☐	☐	☐	☐
c. cannabis (marijuana, pot, grass, hash, etc.)?	☐	☐	☐	☐	☐	☐
d. cocaine (coke, crack, etc.)?	☐	☐	☐	☐	☐	☐
e. prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)?	☐	☐	☐	☐	☐	☐
f. methamphetamine (speed, crystal meth, ice, etc.)?	☐	☐	☐	☐	☐	☐
g. inhalants (nitrous oxide, glue, gas, paint thinner, etc.)?	☐	☐	☐	☐	☐	☐
h. sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)?	☐	☐	☐	☐	☐	☐
i. hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)?	☐	☐	☐	☐	☐	☐
j. street opioids (heroin, opium, etc.)?	☐	☐	☐	☐	☐	☐
k. prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)?	☐	☐	☐	☐	☐	☐
l. other – specify (e-cigarettes, etc.):	☐	☐	☐	☐	☐	☐

B. FUNCTIONING (Continued)

[OPTIONAL: GAF SCORE REPORTED BY GRANTEE STAFF AT PROJECT'S DISCRETION.]

DATE GAF WAS ADMINISTERED: |____|____| / |____|____| /|____|____|____|____|
MONTH DAY YEAR

WHAT WAS THE CONSUMER'S SCORE? GAF = |____|____|____|

B. MILITARY FAMILY AND DEPLOYMENT

[QUESTIONS 7 THROUGH 10 ARE ONLY ASKED AT BASELINE. IF THIS IS NOT A BASELINE GO TO 11.]

7. Have you ever served in the Armed Forces, the Reserves, or the National Guard?

□ YES
□ NO *[GO TO 8.]*
□ REFUSED *[GO TO 8.]*
□ DON'T KNOW *[GO TO 8.]*

***[IF YES]* In which of the following have you ever served? Please answer for each of the following. You may say yes to more than one.**

	YES	NO	REFUSED	DON'T KNOW
Armed Forces	□	□	□	□
Reserves	□	□	□	□
National Guard	□	□	□	□

7a. Are you currently serving on active duty in the Armed Forces, the Reserves, or the National Guard?

□ YES
□ NO *[GO TO 7b.]*
□ REFUSED *[GO TO 7b.]*
□ DON'T KNOW *[GO TO 7b.]*

***[IF YES]* In which of the following are you currently serving? Please answer for each of the following. You may say yes to more than one.**

	YES	NO	REFUSED	DON'T KNOW
Armed Forces	□	□	□	□
Reserves	□	□	□	□
National Guard	□	□	□	□

B. MILITARY FAMILY AND DEPLOYMENT (Continued)

7b. Have you ever been deployed to a combat zone?

- ☐ YES
- ☐ NO *[GO TO 8.]*
- ☐ REFUSED *[GO TO 8.]*
- ☐ DON'T KNOW *[GO TO 8.]*

[IF YES] **To which of the following combat zones have you been deployed? Please answer for each of the following. You may say yes to more than one.**

	YES	NO	REFUSED	DON'T KNOW
Iraq or Afghanistan (e.g., Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn)	☐	☐	☐	☐
Persian Gulf (Operation Desert Shield or Desert Storm)	☐	☐	☐	☐
Vietnam/Southeast Asia	☐	☐	☐	☐
Korea	☐	☐	☐	☐
WWII	☐	☐	☐	☐
Deployed to a combat zone not listed above (e.g., Somalia, Bosnia,	☐	☐	☐	☐

8. Is anyone in your family or someone close to you currently serving on active duty in or retired/separated from the Armed Forces, the Reserves, or the National Guard?

- ☐ Yes, only one person
- ☐ Yes, more than one person
- ☐ No
- ☐ REFUSED
- ☐ DON'T KNOW

B. VIOLENCE AND TRAUMA

9. Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief)?

- ☐ YES
- ☐ NO *[GO TO 11.]*
- ☐ REFUSED *[GO TO 11.]*
- ☐ DON'T KNOW *[GO TO 11.]*

10. Did any of these experiences feel so frightening, horrible, or upsetting that in the past and/or the present you:

	YES	NO	REFUSED	DON'T KNOW
10a. Have had nightmares about it or thought about it when you did not want to?	☐	☐	☐	☐
10b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?	☐	☐	☐	☐
10c. Were constantly on guard, watchful, or easily startled?	☐	☐	☐	☐
10d. Felt numb and detached from others, activities, or your surroundings	☐	☐	☐	☐

B. VIOLENCE AND TRAUMA (Continued)

11. In the past 30 days, how often have you been hit, kicked, slapped, or otherwise physically hurt?

- ☐ Never
- ☐ Once
- ☐ A few times
- ☐ More than a few times
- ☐ REFUSED
- ☐ DON'T KNOW

C. STABILITY IN HOUSING

1. In the past 30 days how many …	**Number of Nights/ Times**	**REFUSED**	**DON'T KNOW**
a. nights have you been homeless?	|___|___|	☐	☐
b. nights have you spent in a hospital for mental health care?	|___|___|	☐	☐
c. nights have you spent in a facility for detox/inpatient or residential substance abuse treatment?	|___|___|	☐	☐
d. nights have you spent in correctional facility including jail, or prison?	|___|___|	☐	☐
[ADD UP THE TOTAL NUMBER OF NIGHTS SPENT HOMELESS, IN HOSPITAL FOR MENTAL HEALTH CARE, IN DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT, OR IN A CORRECTIONAL FACILITY. (ITEMS A-D, CANNOT EXCEED 30 NIGHTS).]	|___|___|		
e. times have you gone to an emergency room for a psychiatric or emotional problem?	|___|___|	☐	☐

[IF 1A, 1B, 1C, OR 1D IS 16 OR MORE NIGHTS, GO TO SECTION D.]

C. STABILITY IN HOUSING (Continued)

2. In the past 30 days, where have you been living most of the time?

[DO NOT READ RESPONSE OPTIONS TO THE CONSUMER. SELECT ONLY ONE.]

- ○ OWNED OR RENTED HOUSE, APARTMENT, TRAILER, ROOM
- ○ SOMEONE ELSE'S HOUSE, APARTMENT, TRAILER, ROOM
- ○ HOMELESS (SHELTER, STREET/OUTDOORS, PARK)
- ○ GROUP HOME
- ○ ADULT FOSTER CARE
- ○ TRANSITIONAL LIVING FACILITY
- ○ HOSPITAL (MEDICAL)
- ○ HOSPITAL (PSYCHIATRIC)
- ○ DETOX/INPATIENT OR RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
- ○ CORRECTIONAL FACILITY (JAIL/PRISON)
- ○ NURSING HOME
- ○ VA HOSPITAL
- ○ VETERAN'S HOME
- ○ MILITARY BASE
- ○ OTHER HOUSED (SPECIFY) _____
- ○ REFUSED
- ○ DON'T KNOW

3. **In the last 4 weeks …**

[READ THE QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

QUESTION	RESPONSE OPTIONS						
In the last 4 weeks …	**Very Dissatisfied**	**Dissatisfied**	**Neither Satisfied nor Dissatisfied**	**Satisfied**	**Very Satisfied**	**REFUSED**	**DON'T KNOW**
a. how satisfied are you with the conditions of your living place?	□	□	□	□	□	□	□

D. EDUCATION AND EMPLOYMENT

1. Are you currently enrolled in school or a job training program?
***[IF ENROLLED]* Is that full time or part time?**

- ○ NOT ENROLLED
- ○ ENROLLED, FULL TIME
- ○ ENROLLED, PART TIME
- ○ OTHER (SPECIFY)_____
- ○ REFUSED
- ○ DON'T KNOW

2. What is the highest level of education you have finished, whether or not you received a degree?

- ○ LESS THAN 12TH GRADE
- ○ 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT (GED)
- ○ VOC/TECH DIPLOMA
- ○ SOME COLLEGE OR UNIVERSITY
- ○ BACHELOR'S DEGREE (BA, BS)
- ○ GRADUATE WORK/GRADUATE DEGREE
- ○ REFUSED
- ○ DON'T KNOW

3. Are you currently employed? *[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CONSUMER WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.]*

- ○ EMPLOYED FULL TIME (35+ HOURS PER WEEK, OR WOULD HAVE BEEN)
- ○ EMPLOYED PART TIME
- ○ UNEMPLOYED, LOOKING FOR WORK
- ○ UNEMPLOYED, DISABLED
- ○ UNEMPLOYED, VOLUNTEER WORK
- ○ UNEMPLOYED, RETIRED
- ○ UNEMPLOYED, NOT LOOKING FOR WORK
- ○ OTHER (SPECIFY) _____
- ○ REFUSED
- ○ DON'T KNOW

3a. *[IF EMPLOYED]*

	Yes	No	REFUSED	DON'T KNOW
• **Are you paid at or above the minimum wage[1]?**	☐	☐	☐	☐
• **Are your wages paid directly to you by your employer?**	☐	☐	☐	☐
• **Could anyone have applied for this job?**	☐	☐	☐	☐

[1] For information on Federal minimum wage go to http://www.dol.gov/dol/topic/wages/.

D. EDUCATION AND EMPLOYMENT

4. In the last 4 weeks …

[READ THE QUESTION FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

QUESTION	RESPONSE OPTIONS						
In the last 4 weeks …	**Not at All**	**A Little**	**Moderately**	**Mostly**	**Completely**	**REFUSED**	**DON'T KNOW**
a. have you enough money to meet your needs?	☐	☐	☐	☐	☐	☐	☐

E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you been arrested?

|____|____| TIMES ☐☐REFUSED ☐☐DON'T KNOW

[IF THIS IS A BASELINE, GO TO SECTION G. OTHERWISE, GO TO SECTION F.]

F. PERCEPTION OF CARE

[SECTION F IS NOT COLLECTED AT BASELINE. FOR BASELINE INTERVIEWS, GO TO SECTION G.]

1. In order to provide the best possible mental health and related services, we need to know what you think about the services you received <u>during the past 30 days</u>, the people who provided it, and the results. Please indicate your disagreement/agreement with each of the following statements.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**	**NOT APPLICABLE**
a. Staff here believe that I can grow, change and recover.	☐	☐	☐	☐	☐	☐	
b. I felt free to complain.	☐	☐	☐	☐	☐	☐	
c. I was given information about my rights.	☐	☐	☐	☐	☐	☐	

F. PERCEPTION OF CARE (Continued)

STATEMENT	RESPONSE OPTIONS						
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**	**NOT APPLICABLE**
d. Staff encouraged me to take responsibility for how I live my life.	☐	☐	☐	☐	☐	☐	
e. Staff told me what side effects to watch out for.	☐	☐	☐	☐	☐	☐	☐
f. Staff respected my wishes about who is and who is not to be given information about my treatment.	☐	☐	☐	☐	☐	☐	☐
g. Staff were sensitive to my cultural background (race, religion, language, etc.).	☐	☐	☐	☐	☐	☐	
h. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	☐	☐	☐	☐	☐	☐	☐
i. I was encouraged to use consumer run programs (support groups, drop-in centers, crisis phone line, etc.).	☐	☐	☐	☐	☐	☐	☐
j. I felt comfortable asking questions about my treatment and medication.	☐	☐	☐	☐	☐	☐	☐
k. I, not staff, decided my treatment goals.	☐	☐	☐	☐	☐	☐	
l. I like the services I received here.	☐	☐	☐	☐	☐	☐	
m. If I had other choices, I would still get services from this agency.	☐	☐	☐	☐	☐	☐	
n. I would recommend this agency to a friend or family member.	☐	☐	☐	☐	☐	☐	

2. ***[INDICATE WHO ADMINISTERED SECTION F - PERCEPTION OF CARE TO THE RESPONDENT FOR THIS INTERVIEW.]***

- ☐ ADMINISTRATIVE STAFF
- ○ CARE COORDINATOR
- ○ CASE MANAGER
- ○ CLINICIAN PROVIDING DIRECT SERVICES
- ○ CLINICIAN NOT PROVIDING SERVICES
- ○ CONSUMER PEER
- ○ DATA COLLECTOR
- ○ EVALUATOR
- ○ FAMILY ADVOCATE
- ○ RESEARCH ASSISTANT STAFF
- ○ SELF-ADMINISTERED
- ○ OTHER (SPECIFY) _____

G. SOCIAL CONNECTEDNESS

1. Please indicate your disagreement/agreement with each of the following statements. Please answer for relationships with persons other than your mental health provider(s) over the past 30 days.

[READ EACH STATEMENT FOLLOWED BY THE RESPONSE OPTIONS TO THE CONSUMER.]

STATEMENT	RESPONSE OPTIONS					
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**	**REFUSED**
a. I am happy with the friendships I have.	□	□	□	□	□	□
b. I have people with whom I can do enjoyable things.	□	□	□	□	□	□
c. I feel I belong in my community.	□	□	□	□	□	□
d. In a crisis, I would have the support I need from family or friends.	□	□	□	□	□	□
e. I have family or friends that are supportive of my recovery.	□	□	□	□	□	□
f. I generally accomplish what I set out to do.	□	□	□	□	□	□

[IF YOUR PROGRAM <u>DOES NOT</u> REQUIRE SECTION H:

IF THIS IS A BASELINE INTERVIEW, STOP NOW. THE INTERVIEW IS COMPLETE.]

IF THIS IS A REASSESSMENT INTERVIEW, PLEASE GO TO SECTION I THEN K.]

IF THIS IS A CLINICAL DISCHARGE INTERVIEW, PLEASE GO TO SECTION J THEN K.]

[IF YOUR PROGRAM <u>DOES</u> REQUIRE SECTION H:

IF THIS IS A BASELINE INTERVIEW, PLEASE PROCEED TO SECTION H THEN STOP. THE INTERVIEW WILL BE COMPLETE.]

IF THIS IS A REASSESSMENT INTERVIEW, PROCEED TO SECTION H, THEN I AND K.]

IF THIS IS A CLINICAL DISCHARGE INTERVIEW, PROCEED TO SECTION H, THEN J AND K.]

H. PROGRAM SPECIFIC QUESTIONS

YOU ARE NOT RESPONSIBLE FOR COLLECTING DATA ON ALL SECTION H QUESTIONS. YOUR GPO HAS PROVIDED YOU GUIDANCE ON WHICH SPECIFIC SECTION H QUESTIONS YOU ARE TO COMPLETE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR GPO.

FOR A LIST OF PROGRAMS THAT HAVE PROGRAM SPECIFIC DATA, SEE APPENDIX A OF THE NOMS CLIENT-LEVEL MEASURES FOR DISCRETIONARY PROGRAMS PROVIDING DIRECT SERVICES QUESTION-BY-QUESTION INSTRUCTION GUIDE FOR ADULT PROGRAMS.

H1. PROGRAM SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CONSUMER AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE.]

1. **In the past 30 days, how often have you taken all of your psychiatric medication(s) as prescribed to you?**
   - ○ Always
   - ○ Usually
   - ○ Sometimes
   - ○ Rarely
   - ○ Never
   - ○ REFUSED
   - ○ DON'T KNOW

[QUESTION 2 SHOULD BE REPORTED BY GRANTEE STAFF ABOUT THE CONSUMER AT REASSESSMENT AND CLINICAL DISCHARGE.]

2. **In the past 30 days, how compliant has the consumer been with their treatment plan?**
   - ○ Not compliant
   - ○ Minimally compliant
   - ○ Moderately compliant
   - ○ Highly compliant
   - ○ Fully compliant
   - ○ DON'T KNOW

H2. PROGRAM SPECIFIC QUESTIONS

[QUESTIONS 1 AND 2 SHOULD BE REPORTED BY GRANTEE STAFF AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE.

1. Did the consumer screen positive for a mental health disorder?

- ☐ Consumer screened positive
- ☐ Consumer screened negative
- ☐ Consumer was not screened

a. *[IF CONSUMER SCREENED POSITIVE]* Was the consumer referred to the following type of services?

	YES	NO
Mental health services	☐	☐

b. *[IF CONSUMER WAS REFERRED TO SERVICES]* Did they receive the following services?

	YES	NO	DON'T KNOW	NOT APPLICABLE
Mental health services	☐	☐	☐	☐

2. Did the consumer screen positive for a substance use disorder?

- ☐ Consumer screened positive
- ☐ Consumer screened negative
- ☐ Consumer was not screened

a. *[IF CONSUMER SCREENED POSITIVE]* Was the consumer referred to the following type of services?

	YES	NO
Substance use disorder services	☐	☐

b. *[IF CONSUMER WAS REFERRED TO SERVICES]* Did they receive the following services?

	YES	NO	DON'T KNOW	NOT APPLICABLE
Substance use disorder services	☐	☐	☐	☐

[QUESTION 3 SHOULD BE ANSWERED BY THE CONSUMER AT REASSESSMENT AND CLINICAL DISCHARGE.]

3. Please indicate the degree to which you agree or disagree with the following statement:

Receiving community-based services through the [insert grantee name] program has helped me to avoid further contact with the police and the criminal justice system.

- ○ Strongly Disagree
- ○ Disagree
- ○ Undecided
- ○ Agree
- ○ Strongly Agree
- ○ REFUSED
- ○ DON'T KNOW

H3. PROGRAM SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CONSUMER AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE.]

		Number of Times	REFUSED	DON'T KNOW
1.	**In the past 30 days how many times have you …**			
	a. Been to the emergency room for a physical health care problem?	|___|___|	☐	☐
	b. Been hospitalized overnight for a physical health care problem? ***[REPORT NUMBER OF NIGHTS HOSPITALIZED]***	|___|___|	☐	☐

[QUESTION 2 SHOULD BE REPORTED BY GRANTEE STAFF AT BASELINE, REASSESSMENT AND CLINICAL DISCHARGE.]

2. Please indicate which type of funding source(s) was (were)/will be used to pay for the services provided to this consumer since their last interview. (Check all that apply):

- ○ Current SAMHSA grant funding
- ○ Other federal grant funding
- ○ State funding
- ○ Consumer's private insurance
- ○ Medicaid/Medicare
- ○ Other (Specify): _____

[PROGRAM-SPECIFIC HEALTH ITEMS ARE REPORTED BY THE GRANTEE ABOUT THE CONSUMER.]

Program-Specific Health Items (Report Quarterly)

1. Health measurements:

a.	Systolic blood pressure		mmHg	
b.	Diastolic blood pressure		mmHg	
c.	Weight		kg	
d.	Height		cm	
e.	Waist circumference	_____	cm	
f.	Breath CO - for smoking status		ppm	

2. Did patient successfully fast for 8 hours prior to providing the blood sample? ☐

3. Blood test results:

a. Date of blood draw: |__|__| / |__|__| /|__|__|__|__|
MONTH DAY YEAR

[FOR 3b AND 3c: ENTER ONE OR THE OTHER, NOT BOTH.]

b.	Fasting plasma glucose		mg/dL	
c.	HgBA1c		%	
d.	Total Cholesterol		mg/dL	
e.	HDL Cholesterol		mg/dL	
f.	LDL Cholesterol		mg/dL	
g.	Triglycerides		mg/dL	

H4. PROGRAM SPECIFIC QUESTIONS

[QUESTIONS 1 AND 2 SHOULD BE ANSWERED BY THE CONSUMER AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE.]

1a. Did the program provide an HIV test?

- ○ Yes
- ○ No ***[SKIP TO H1b]***
- ○ REFUSED ***[SKIP TO H1b]***
- ○ DON'T KNOW ***[SKIP TO H1b]***

[IF YES] **What was the result?**

- ○ Positive
- ○ Negative ***[SKIP TO H1b]***
- ○ Indeterminate ***[SKIP TO H1b]***
- ○ REFUSED ***[SKIP TO H1b]***
- ○ DON'T KNOW ***[SKIP TO H1b]***

[IF CONSUMER SCREENED POSITIVE] **Were you connected to HIV treatment services?**

- ○ Yes
- ○ No
- ○ REFUSED
- ○ DON'T KNOW

1b. Did the program provide a Hepatitis B (HBV) test?

- ○ Yes
- ○ No ***[SKIP TO H1c]***
- ○ REFUSED ***[SKIP TO H1c]***
- ○ DON'T KNOW ***[SKIP TO H1c]***

[IF YES] **What was the result?**

- ○ Positive
- ○ Negative ***[SKIP TO H1c]***
- ○ Indeterminate ***[SKIP TO H1c]***
- ○ REFUSED ***[SKIP TO H1c]***
- ○ DON'T KNOW ***[SKIP TO H1c]***

[IF CONSUMER SCREENED POSITIVE] **Were you connected to HBV treatment services?**

- ○ Yes
- ○ No
- ○ REFUSED
- ○ DON'T KNOW

1c. Did the program provide a Hepatitis C (HCV) test?

- ○ Yes
- ○ No ***[SKIP TO H2a]***
- ○ REFUSED ***[SKIP TO H2a]***
- ○ DON'T KNOW ***[SKIP TO H2a]***

[IF YES] **What was the result?**

- ○ Positive
- ○ Negative ***[SKIP TO H2a]***
- ○ Indeterminate ***[SKIP TO H2a]***
- ○ REFUSED ***[SKIP TO H2a]***
- ○ DON'T KNOW ***[SKIP TO H2a]***

[IF CONSUMER SCREENED POSITIVE] **Were you connected to HCV treatment services?**

- ○ Yes
- ○ No
- ○ REFUSED
- ○ DON'T KNOW

2a. ***[If HIV STATUS IS POSITIVE]*** **Did you receive a referral from [grantee] to medical care?**

- ○ Yes
- ○ No
- ○ REFUSED
- ○ DON'T KNOW

2b. Have you been prescribed an antiretroviral medication (ART)?

- ○ Yes
- ○ No ***[SKIP TO SECTION I OR J/K]***
- ○ REFUSED ***[SKIP TO SECTION I OR J/K]***
- ○ DON'T KNOW ***[SKIP TO SECTION I OR J/K]***

[FOR CONSUMERS WHO REPORT BEING PRESCRIBED AN ART] **In the past 30 days how often have you taken your ART as prescribed to you?**

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never
- ○ REFUSED
- ○ DON'T KNOW
- ○ NOT APPLICABLE

  (IF THE PRESCRIPTION WAS GIVEN FOR THE FIRST TIME AT THIS APPOINTMENT, SELECT NOT APPLICABLE.)

H5. PROGRAM SPECIFIC QUESTIONS

[QUESTIONS 1 AND 2 SHOULD BE REPORTED BY GRANTEE STAFF AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE.]

1. Did the consumer screen positive for a mental health disorder?

- ☐ Consumer screened positive
- ☐ Consumer screened negative
- ☐ Consumer was not screened

a. *[IF CONSUMER SCREENED POSITIVE]* Was the consumer referred to the following type of services?

	YES	NO
Mental health services	☐	☐

b. *[IF CONSUMER WAS REFERRED TO SERVICES]* Did they receive the following services?

	YES	NO	DON'T KNOW	NOT APPLICABLE
Mental health services	☐	☐	☐	☐

2. Did the consumer screen positive for a substance use disorder?

- ☐ Consumer screened positive
- ☐ Consumer screened negative
- ☐ Consumer was not screened

a. *[IF CONSUMER SCREENED POSITIVE]* Was the consumer referred to the following type of services?

	YES	NO
Substance use disorder services	☐	☐

b. *[IF CONSUMER WAS REFERRED TO SERVICES]* Did they receive the following services?

	YES	NO	DON'T KNOW	NOT APPLICABLE
Substance use disorder services	☐	☐	☐	☐

H6. PROGRAM SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE ANSWERED BY THE CONSUMER AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE.]

		Number of Times	REFUSED	DON'T KNOW
1.	**In the past 30 days:**			
	a. How many times have you thought about killing yourself?	|___|___|	☐	☐
	b. How many times did you attempt to kill yourself?	|___|___|	☐	☐

[QUESTION 2 SHOULD BE ANSWERED BY THE CONSUMER AT REASSESSMENT AND CLINICAL DISCHARGE.]

2. How often does a member of your team interact with you?

- ○ Several times a day
- ○ Almost every day
- ○ A few times a week
- ○ About once a week
- ○ A few times a month
- ○ About once a month
- ○ Less than once per month
- ○ REFUSED
- ○ DON'T KNOW

H7. PROGRAM SPECIFIC QUESTIONS

[QUESTION 1 SHOULD BE REPORTED BY GRANTEE STAFF AT REASSESSMENT AND CLINICAL DISCHARGE]

1. **Has the consumer experienced a first episode of psychosis (FEP) since their last interview?**

   - ☐ YES
   - ☐ NO
   - ☐ DON'T KNOW

   a. [IF YES] Please indicate the approximate date that the consumer initially experienced the FEP.

   |__|__| /|__|__|__|__|
   MONTH YEAR

   b. [IF YES] Was the consumer referred to FEP services?

   - ☐ YES
   - ☐ NO
   - ☐ DON'T KNOW

   [IF CONSUMER WAS REFERRED TO FEP SERVICES] Please indicate the date that the consumer first received FEP services/treatment.

   |__|__| /|__|__|__|__| DON'T KNOW
   MONTH YEAR ☐

[QUESTION 2 SHOULD BE ANSWERED BY THE CONSUMER AT BASELINE, REASSESSMENT, AND CLINICAL DISCHARGE IF THEY ARE CURRENTLY ENROLLED IN SCHOOL.]

2. **[IF THE CONSUMER INDICATED THAT THEY WERE ENROLLED IN SCHOOL] During the past 30 days of school, how many days were you absent for any reason?**

   |____|____| # OF DAYS ☐☐REFUSED ☐☐DON'T KNOW ☐☐NOT APPLICABLE

H8. PROGRAM SPECIFIC QUESTIONS

[PROGRAM-SPECIFIC HEALTH ITEMS ARE REPORTED BY THE GRANTEE ABOUT THE CONSUMER.]

1. Health measurements: (Report Quarterly)

a.	Systolic blood pressure		mmHg	
b.	Diastolic blood pressure		mmHg	
c.	Weight		kg	
d.	Height		cm	
e.	Waist circumference	_____	cm	

[IF THIS IS A BASELINE, STOP HERE.]

[IF THIS IS A REASSESSMENT, GO TO SECTION I.]

[IF THIS IS A CLINICAL DISCHARGE, GO TO SECTION J.]

I. REASSESSMENT STATUS

[SECTION I IS REPORTED BY GRANTEE STAFF AT REASSESSMENT.]

1. Have you or other grant staff had contact with the consumer within 90 days of the last encounter?

- ☐ Yes
- ☐ No

2. Is the consumer still receiving services from your project?

- ☐ Yes
- ☐ No

[GO TO SECTION K.]

J. CLINICAL DISCHARGE STATUS

[SECTION J IS REPORTED BY GRANTEE STAFF ABOUT THE CONSUMER AT CLINICAL DISCHARGE.]

1. On what date was the consumer discharged?

|____|____| / |____|____ |___|____|
MONTH YEAR

2. What is the consumer's discharge status?

- ☐ Mutually agreed cessation of treatment
- ○ Withdrew from/refused treatment
- ☐ No contact within 90 days of last encounter
- ☐ Clinically referred out
- ☐ Death
- ☐ Other (Specify) _____

[GO TO SECTION K.]

K. SERVICES RECEIVED

[SECTION K IS REPORTED BY GRANTEE STAFF AT REASSESSMENT AND DISCHARGE UNLESS THE CONSUMER REFUSED THIS INTERVIEW OR ALL INTERVIEWS, IN WHICH CASE IT IS OPTIONAL.]

1. On what date did the consumer last receive services?

|____|____| / |____|____|____|____|
MONTH YEAR

[IDENTIFY ALL OF THE SERVICES YOUR PROJECT PROVIDED TO THE CONSUMER <u>SINCE HIS/HER LAST NOMS INTERVIEW</u>; THIS INCLUDES CMHS-FUNDED AND NON-FUNDED SERVICES.]

Core Services	**Provided**			
	Yes	**No**	**UNKNOWN**	**SERVICE NOT AVAILABLE**
1. Screening	☐	☐	☐	☐
2. Assessment	☐	☐	☐	☐
3. Treatment Planning or Review	☐	☐	☐	☐
4. Psychopharmacological Services	☐	☐	☐	☐
5. Mental Health Services	☐	☐	☐	☐

[IF THE ANSWER TO 5 'MENTAL HEALTH SERVICES' IS YES, PLEASE ESTIMATE HOW FREQUENTLY MENTAL HEALTH SERVICES WERE DELIVERED.]

Number of times_____per

- ○ Day
- ○ Week
- ○ Month
- ○ Year

UNKNOWN ☐

	Yes	**No**	**UNKNOWN**	**SERVICE NOT AVAILABLE**
6. Co-Occurring Services	☐	☐	☐	☐
7. Case Management	☐	☐	☐	☐
8. Trauma-specific Services	☐	☐	☐	☐
9. Was the Consumer referred to another provider for any of the above core services?	☐	☐	☐	

Support Services	**Provided**			
	Yes	**No**	**UNKNOWN**	**SERVICE NOT AVAILABLE**
1. Medical Care	☐	☐	☐	☐
2. Employment Services	☐	☐	☐	☐
3. Family Services	☐	☐	☐	☐
4. Child Care	☐	☐	☐	☐
5. Transportation	☐	☐	☐	☐
6. Education Services	☐	☐	☐	☐
7. Housing Support	☐	☐	☐	☐
8. Social Recreational Activities	☐	☐	☐	☐
9. Consumer Operated Services	☐	☐	☐	☐
10. HIV Testing	☐	☐	☐	☐
11. Was the Consumer referred to another provider for any of the above support services?	☐	☐	☐	☐